

CONTEMPORARY SUPPORTS AND SERVICES FOR ADULTS WITH SEVERE MENTAL ILLNESS

Preliminary Draft Prepared for the State of Iowa By

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Table of Contents

Introduction to the Revised Edition	3
Introduction: Adult Mental Health Supports and Services	5
1.0 Purpose	5
2.0 Foundations	5
3.0 Best Practice.....	7
4.0 Contemporary Practice Implications.....	8
Quadrant Model.....	9
Assertive Community Treatment Team	10
Brief Description	10
Intended Outcomes	15
Consumer Operated Drop in Center	16
Brief Description:	16
Intended Outcomes	18
Crisis Stabilization Services	20
Brief Description	20
Intended Outcomes	23
Family Psychoeducation	25
Brief Description	25
Intended Outcomes	27
Illness Self-Management & Recovery	29
Brief Description	29
Intended Outcomes	31
Intergraded Dual Disorder Treatment Team	33
Brief Description	33
Intended Outcomes	37
Partial Hospital Program	39
Brief Description	39
Intended Outcomes	40

Peer Support Specialist Services	41
Brief Description	41
Intended Outcomes	44
Psychosocial Clubhouse	45
Brief Description	45
Intended Outcomes	48
Recovery Supports Model of Practice.....	50
Adults with Serious Mental Illness that are advanced in their recovery process.	50
Brief Description	50
Intended Outcomes	52
Supported Employment.....	54
Brief Description	54
Intended Outcomes	56
Targeted Case Management.....	57
Brief Description	57
Intended Outcomes	59
Telemental Health.....	60
Brief Description	60
Intended Outcomes	63
References	65

Introduction to the Revised Edition

The issue of "core services" has been debated in Iowa for many years. Thus far there has been little to show for all the energy and work expended in these debates.

The debate often gets hung up on calls from advocates who argue for all services at all places for all clients, and that obviously is not feasible. How do we balance this with the very reasonable call for a "safety net" of necessary services to be available *to the right people in the right place at the right time?*

Moving to a regional model of publicly funded mental health services may make this a more tractable problem. Rather than saying that all services be available to all people in all places, it is reasonable to suggest that each region have a set of core services for all adults with serious mental illness. The decision about which services should be so prioritized and mandated should be based on the best available evidence that they are effective for priority outcomes.

In 2010, a version of this white paper was developed by the consulting firm of Pareto Solutions. It summarizes the evidence base (including research evidence, expert opinion and clinical experience) for a broad array of services to adults with serious mental illness. The white paper was revised and updated by the Iowa Consortium for Mental Health in 2011. The revised version follows in these materials.

The introductory material on pages 5-9 provide the conceptual framework and background for how the material is laid out. Each type of service is briefly described, along with its target population (defined in LOCUS terms), staffing needs, expected duration of service and intended outcomes. More than a dozen specific practices are included, some described in more detail than others. This list is not comprehensive, but we hope it provides a reasonable starting point.

3 types of services deserve particular attention in terms of need in our current system.

24/7 crisis intervention services: Perhaps the greatest single gap in Iowa's current mental health system is the lack of consistent high quality crisis intervention and stabilization services. Individuals with serious mental illness in crisis often have nowhere to turn other than under-resourced emergency rooms that may be a long way from their home. A telephone hotline that directs people to their local emergency room if they are suicidal simply will not suffice. Every region should have a hub of state-of-the-art mental health evaluation and crisis stabilization capacity. Ideally, this should include the following components: 1) 24-7 crisis hot-line, ideally staffed by individuals who will see the person directly in the ER if the case is unable to be diverted; 2) mobile crisis capacity; 3) fact-to-face evaluation and treatment capacity by a licensed independent mental health professional, with access to medications and inpatient hospitalization if necessary; 4) 23 or 47 hour observation units; 5) access to non-hospital-based emergency housing and crisis stabilization beds; 6) short term crisis case management and follow-up.

Assertive community treatment: Currently there are five assertive community treatment programs in Iowa, serving approximately 250 patients. It is estimated that approximately 1250 individuals in Iowa would be expected to qualify for, and benefit from this service at any time. Ideally, every region should provide access to at least one assertive community treatment team.

Supported employment: More than 75% of all adults in Iowa receiving publicly funded services for serious mental illness in Iowa are chronically unemployed. Being engaged in meaningful activities, either work or educational, is critical in promoting recovery, and fundamental to the spirit of Olmstead. The good news is that there are evidence-based practices that are effective in helping adults with serious mental illness gain appropriate, satisfying and enduring employment – that practice is Supported Employment. The bad news is that this practice is markedly under-utilized in Iowa relative to vocational practices such as sheltered workshop or other “pre-vocational activities” that do not yield good outcomes for this population. A core component of the evidence-based practice of supported employment is meaningful integration of the employment and mental health services; the mental health agency does not necessarily have to provide the employment services directly, but they must have policies and procedures that allow them to meaningfully interact with the vocational provider on shared cases. Mental health services will not move into the 21st century if until meaningful employment is prioritized.

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Introduction: Adult Mental Health Supports and Services

1.0 Purpose

The purpose of this document is to provide “Best Practice” applied field practice information regarding supports and services for adults diagnosed with severe and persistent mental illness. The intent of this document is to provide a learning resource in order to inform and guide policy and therefore influence field practice applications.

2.0 Foundations

No individual support or service or Model of Practice exists in a vacuum. Models of Practice may be well defined operationally, but they also require a coherent philosophy of care, a foundation based on empirical outcomes, or a coherent set of “values” about how to treat people. The ultimate intended outcome of these supports and services is to help people become fully contributing citizens of their communities.

“Best Practice” models may be diagnoses-specific practice guidelines and pathways - cost-based or values-based models that reflect research and expert consensus. Recent national attention to evidence-based care that relies on scientific data points out the lack of outcomes research in mental health. Manderscheid, (2001) Chief of the CMS Survey and Research Analysis Branch was quoted in a November 2001 edition of *Mental Health Weekly* regarding his concern about the lack of research and the need for administrators to find a way to research best practices despite lack of funding for innovative approaches (Anthony, 2001). This report focuses on preferred service models that incorporate best practices for persons with severe and persistent mental illness. Incorporated within this report are research-based data as well as costs for delivery when available. However, many of the recommendations are value-based and reflective of consensus and anecdotal success. Since services are generally of more value if embraced by the people receiving the service, this paper presents a consensus of views consumers have discovered during their personal journeys. Evidence has been collected, as available, to support their opinions.

2.1 Best Practices/Values of the System

To implement best practices, a culture must be created (or exist) that encompasses skilled, visionary leadership, expert staff, clearly articulated principles and values, and involvement of a wide range of stakeholders. Best practice values underlie each component of the service system. A review of state projects, national demonstration projects, Canadian best practices, Office of the Inspector General reports, research by

the National Association of State Mental Health Program Directors, stakeholder input and numerous journal articles yielded the following commonly proposed values and best practices for the system.

Consumers do best when:

- The focus is on maximum recovery and independence with support extending beyond symptom control.
- There is a personal exercise of choice and control in all aspects of life.
- There is recognition and support of cultural norms and traditions.
- Meaningful relationships with family and friends are promoted.
- There are opportunities for giving back to the community.
- Care and supports are integrated/coordinated across providers.
- Treatment ethics and rights protections for the consumer are paramount.
- Intervention is early and sustained to reduce chronic disability and long-term cognitive deficits.

2.2 Four Components of Recovery

The four components of recovery are honored

1. Instillation of hope and a positive outlook for the future
 2. Empowerment
 3. Self-determination
 4. Meaningful work and roles in life
- Recovery support is a process that incorporates a tolerance for "set backs", and the care environment is flexible, allowing for the ups and downs of the illness while incorporating self-determination.
 - People are viewed as partners in their care. Concepts called person-centered planning or individualized treatment planning require personal choice and a match of services that respects individual needs and goals.
 - Clinical decisions are evidence-based.

A longitudinal outcomes study, done in Ohio, clearly determined that approaches that incorporate person-centered values are most effective. For example, consumers' perceptions that their needs were met were the best predictors of positive outcomes versus the amounts or types of services received, (Carstens, 1999). The study also demonstrated that case managers' perceptions of a consumer's unmet needs are different than the consumers' perception of need. The variable most highly correlated with consumer satisfaction that their needs were met was their own active involvement in treatment planning and decision- making.

2.3 Community Benefit

All individuals are contributors to the interpersonal, social, civic, economic and moral fabric of the community. All of the community benefits with the inclusion of supportive recovery oriented valued roles for people labeled/diagnosed with mental illness. The greatest method of diminishing stereotypes and stigma is through community experience of people labeled/diagnosed with mental illness contributing in the same manner as other community members with the community learning through their involvement and building natural empathy regarding support and recovery as simply no different than the variety of ways other community members who share a particular specific sub-set of life experiences, conditions, situations and circumstances (e.g.; individuals with physical disabilities, older persons, cultural groups) are supported in order to achieve the collective community interest. Correspondingly, community benefit are generated with the community embracing and supporting the unique needs of groups of community members to assure ample opportunities for them to contribute and benefit (e.g.; accessible buildings, specialized resources and services available).

As is evident, community benefit extends well beyond adults diagnosed with severe and persistent mental illness as it is a benefit to the full community. This includes community prevention and intervention efforts promoting real individual and public safety. Jail diversion efforts, particularly including law enforcement and mental health partnered Crisis Intervention Teams serves to diminish episodes of incarceration as well as providing informed interventions which minimizes risks related to individuals, law enforcement agents and the public (Florida CIT Coalition, 2005; Reuland, 2004; and Schwarzfeld, Reuland, & Plotkin, 2008).

3.0 Best Practice

There is an ever increasing demand that public funds be scrutinized as accountable for “results”, or positive outcomes. Process measures, such as the number of service units provided does not speak to what was actually achieved as a result of providing the services. Concerns such as cost-benefit, and more importantly, Return on Investment (ROI), have become critical in securing financing for supports and services. ROI is defined as the investment of public funds in an individual (and/or community) with the intention of measuring whether or not the funds have provided a “dividend” related to the individual living a supported life as a contributing member of the community. Hopefully, the total aggregate investment of funds is less than the aggregate dividend or value the community experiences. The need for precision in identifying what supports and services are going to be provided, relative to the ROI standard, will place an increasing demand on mental health managers and providers who will seek well defined practices that demonstrate or show great promise of having a positive ROIs and demonstrable positive outcomes.

Best Practice includes Evidence-Based Practices (EBPs), as well as Promising and Emerging Practices (PEPs) (Hyde, Falls, Morris, Jr., & Schoenwald, 2003). For a support or service to be categorized as an **Evidence-Based Practice (EBP)** it must be based on sufficiently sound scientific trials and outcome research. **Promising and**

Emerging Best Practices requires some level of systematic inquiry and sufficient consensus among academic and field experts that the Model of Practice demonstrates “promise” relative to intended outcomes..

Values-based Practice is an additional Best Practice category William Anthony “coined” the term value-based practices, which are a set of recovery-oriented practices that consumers value, desire, and participate in as “practitioners”. Examples include Spell out the four words before using the acronym (WRAP), Drop-In Center models that promote active recovery, and other peer-delivered supports and services.

For the purpose both formative and summative evaluation and continuous quality improvement efforts Best Practices share two key characteristics: (1) **Model Fidelity** requires the program to be implemented according to well-defined defined operational requirements (e.g. staffing, locations, days/hours of operation, etc). **Intended Outcomes** requires the establishment and measurement of relevant (valid) and accurate (reliable) outcomes that ultimately respond to the question “*Did this service/support have a positive and lasting effect on the life of this individual?*” Outcomes are related to “real life” outcomes such as individuals having sustainable housing, jobs, and relationships

4.0 Contemporary Practice Implications

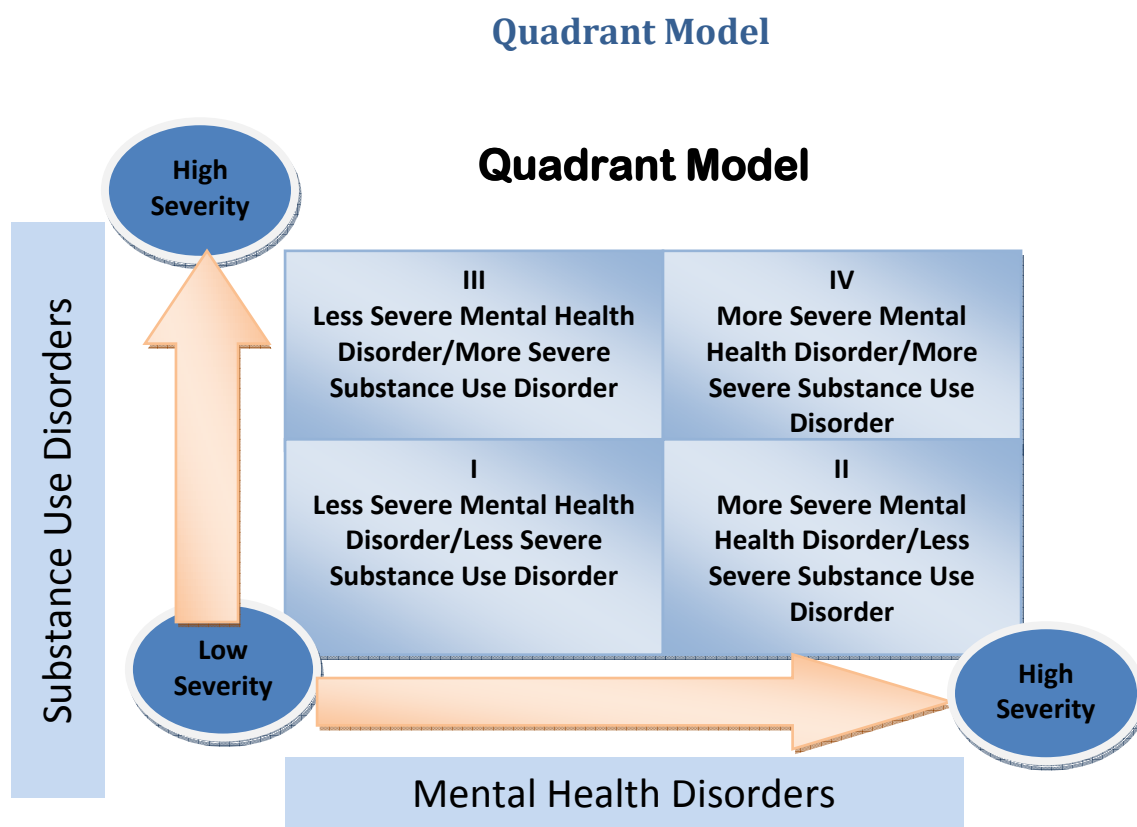
The development of the Cost Model is clearly a sound and critical method for the establishment of state policy. Although not to be confused with what the Cost Model is designed to accomplish, the establishment of state policy offering direction regarding empirically relevant and sound standards will serve to promote fundamental fairness in the management and delivery of supports and services.

There are two components that can help build contemporary models of practice, programs, and service options: 1) Standard Assessment; and 2) Constructs for care decisions. Standard assessments allow for multiple practitioners to understand the needs of an individual similarly and aids in the consistency of treatment decisions for like people. Some states use a standard assessment for each population such as the Supports Intensity Scale (SIS) for adults with developmental disabilities; the Level of Care Utilization System (LOCUS) for adults with mental illness and co-occurring substance use disorders; Child & Adolescent Level of Care Utilization System (CALOCUS) or Child & Adolescent Functional Assessment Scale (CAFAS) for children with serious emotional disturbances. Regardless of the standard assessment used, the idea of quantifying the intensity of need and predicting corresponding supports and services, including costs, are valuable strategies for system transformation efforts toward outcome based services and cost modeling efforts.

Constructs for care decisions help local-level clinicians make decisions at the beginning of services (informed referrals from access points), authorization service payment decisions through the person-centered planning process by staff who know the person best, and as triggers for transitions to lower levels of service. These constructs can take

many forms. For instance, states may develop utilization management authorization decision guidelines that are anchored on the standard assessment such as Kay Hodges' CAFAS Tiers[®]. Other states use the SIS to predict the cost of service utilization and create individual budgets for adults with developmental disabilities. An example of a construct that is fast becoming universally accepted is the Four Quadrant Model for Mental Health and Co-occurring Substance Use.

The Four Quadrant Model builds on the 1998 consensus document for mental health and substance abuse/addiction service integration. This model, of comprehensive, continuous and integrated system of care, describes differing levels of mental health and substance abuse integration and clinician competencies based on the four-quadrant model, divided into severity for each disorder:



Another contemporary construct for the behavioral health system is the Trans-theoretical Model often referred to as Stage of Change and Treatment Matching (or Stage Wise or Stage Matched treatment). The basic idea is that in order to get the best outcomes for people and not waste precious resources, the person's services should be matched to their stage of change. Stage of change can predict service types and give practitioners specific approaches that have the highest probability of being effective. This construct is used in a variety of change processes including mental health substance use (as shown below), health care (e.g. following a Diabetic diet, quitting smoking, cancer treatment, etc.), or any other change process.

Assertive Community Treatment Team

Support or Service

Assertive Community Treatment (ACT) Team

Targeted Case Cohort

Adults with serious and persistent mental illness and co-occurring substance use disorders

Best Practice Classification

Evidenced Based Practice

Brief Description

As an evidence-based psychiatric rehabilitation practice, ACT provides a comprehensive approach to service delivery to consumers with severe mental illness (SMI). ACT uses a multidisciplinary team, which typically includes a psychiatrist, a nurse, and at least two case managers. ACT is characterized by (1) low client to staff ratios; (2) providing services in the community rather than in the office; (3) shared caseloads among team members; (4) 24-hour staff availability, (5) direct provision of all services by the team (rather than referring consumers to other agencies); and (6) time-unlimited services in order to support the person in an independent living arrangement (Williams & Hradek, 2010; Williams, 2008).

❖ Work with informal support system

Program provides support and skills for client's informal support network (i.e., persons not paid to support client, such as family, landlord, shelter staff, employer or other key person). Developing and maintaining community support further enhances client's integration and functioning.

❖ Responsibility for crisis services

Program has 24-hour responsibility for covering psychiatric crises. An immediate response can help minimize distress when persons with severe mental illness are faced with crisis. When the ACT team provides crisis intervention, continuity of care is maintained.

❖ Responsibility for hospital admissions

ACT team is closely involved in hospital admissions. More appropriate use of psychiatric hospitalization occurs, and continuity of care is maintained, when the ACT team is involved with psychiatric hospitalizations.

❖ **Responsibility for hospital discharge planning**

Program is involved in planning for hospital discharges. Ongoing participation of the ACT team during a client's hospitalization and discharge planning allows the team to help maintain community supports (e.g., housing), and continuity of service.

❖ **Full responsibility for treatment services**

ACT team directly provides psychiatric services and medication management, counseling/psychotherapy, housing support, substance abuse treatment, and employment/rehabilitative services, in addition to case management service. Clients benefit when services are integrated into a single team, rather than when they are referred to many different service providers, furthermore, an integrated approach allows services to be tailored to each client.

❖ **Individualized substance abuse treatment**

Substance use disorders often occur concurrently in persons with SMI; these co-occurring disorders require treatment that directly addresses them. Concurrent substance use disorders are common in persons with severe mental illness. Appropriate assessment and intervention strategies are critical.

❖ **Dual disorder treatment groups**

Program uses group modalities as a treatment strategy for people with substance use disorders. Group treatment has been shown to positively influence recovery for persons with dual disorders.

❖ **Dual disorders (DD) model**

Program uses a stage-wise treatment model that is non-confrontational, follows behavioral principles, considers interactions between mental illness and substance abuse, and has gradual expectations of abstinence. The DD model attends to the concerns of both SMI and substance abuse for maximum opportunity for recovery and symptom management.

❖ **Assertive engagement mechanisms**

Program uses street outreach, legal mechanisms (e.g., probation/parole, OP commitment) or other techniques to ensure ongoing engagement. Clients are not immediately discharged from the program due to failure to keep appointments. Retention of clients is a high priority for ACT teams. Persistent, caring attempts to

engage clients in treatment helps foster a trusting relationship between the client and the ACT team. Assertive outreach is considered a critical feature of the ACT team.

❖ **Community-based services**

Program works to monitor status, develop skills in the community, rather than in office. Contacts in natural settings (i.e., where clients live, work, and interact with other people) are thought to be more effective than when they occur in hospital or office settings, as skills may not transfer well to natural settings. Furthermore, more accurate assessment of the client can occur in his or her community setting because the clinician can make direct observations rather than relying on self-report. Medication delivery, crisis intervention, and networking are more easily accomplished through home visits.

❖ **Admission Criteria**

The ACT program has a clearly identified mission to serve a particular population; it uses measurable and operationally defined criteria to screen out inappropriate referrals. Admission criteria should be pointedly targeted toward the individuals who typically do not benefit from usual services. ACT teams are intended for adults with severe mental illness. In addition to these very general criteria, an ACT team should have some further admission guidelines tailored to their treatment setting. Examples of more specific admission criteria that might be suitable include:

- Pattern of frequent hospital admissions
- Frequent use of emergency services
- Individuals discharged from long-term hospitalizations
- Co-occurring substance use disorders
- Homeless
- Involvement with the criminal justice system
- Not adhering to medications as prescribed
- Not benefiting from usual mental health services (e.g., day treatment)
- ACT is best suited to clients who do not effectively use less intensive mental health services.

❖ **Intake rate**

Program takes clients in at a low rate to maintain a stable service environment. In order to provide consistent, individualized, and comprehensive services to clients, a low growth rate of the client population is necessary. For existing ACT teams, the optimal rate of intake is no greater than 6 clients in 6 months. For new teams, the intake rate will be much higher and dependent upon the number of staff in place. Some systems have had success in start up by identifying consumers appropriate for ACT that are served in other programs or facilities such as state institution or community based medically managed facilities so that the new ACT team has a pool of consumers from which to transition to ACT. With this method, it is optimal for all team members to be in place and begin serving 5-6 new consumers per month until the ACT team reaches full capacity.

This allows new teams time to become thoroughly acclimated to new processes without being overwhelmed by trying to serve a large number of individuals with multiple, complex needs all at once.

Staffing

The entire team shares responsibility for each client; each clinician contributes expertise as appropriate. All team members provide case management although the team includes designated case managers. The team approach ensures continuity of care for clients, and creates a supportive organizational environment for practitioners. Daily team meetings allow ACT practitioners to discuss clients, solve problems, and plan treatment and rehabilitation efforts, ensuring all clients receive optimal service. Although there are standard roles and recommended consumer to staff ratio, each ACT will be composed of professionals that fit the needs of the consumers served on the team. For instance, some ACT Teams may have more employment specialists than case managers depending on local priorities of employment. If employment is not an outcome that is valued, the team may have no employment specialists and more case managers. However, the team is composed, there are required staff and expertise for the team.

- Client/clinician ratio of 10:1- ACT teams should maintain a low consumer to staff ratio in the range of 10:1 in order to ensure adequate intensity and individualization of services.
- Teams typically serve up to 100 consumers in urban areas and approximately 50 in rural areas due to staff travel time
- Required Staffing for ACT Teams staffing per 100 consumers:
 - ✓ 1 FTE Team Leader: One practicing Team Leader who is a mid-level manager, clinical supervisor, and practicing clinician. Most often, the team leader provides individual and group therapy and directs and oversees the team.
 - ✓ 1 FTE Psychiatrist: At least one full-time psychiatrist is assigned to work with the program but not included in the consumer/staff ratio. The psychiatrist serves as medical director for the team; in addition to medication monitoring, the psychiatrist functions as a fully integrated team member, participating in treatment planning and rehabilitation efforts.
 - ✓ 2 FTE Nurses: At least two full-time nurses are assigned to work with the program. The full-time RN has been found to be a critical ingredient in successful ACT programs. The nurses function as full members of the team, which includes conducting home visits, treatment planning, and daily team meetings. Nurses can help administer needed medications and serve to educate the team about important medication issues.

- ✓ 1 FTE Peer: At least one full time peer who provide direct services. Some research has concluded that including consumers as staff on case management teams improves the practice culture, making it more attuned to consumer perspectives.
- ✓ 6 FTE Case Managers: Although all team members provide case management, most ACT teams include designated case managers. The number of case managers can be changed if the team prefers designated employment specialist or additional peers.
- Required expertise:
 - ✓ At least two staff members on the ACT team with at least one year of training or clinical experience in substance abuse treatment. One or more members of the team provide direct treatment and substance abuse treatment for clients with substance use disorders.
 - ✓ At least two staff members with at least one year of training/experience in vocational rehabilitation and support. ACT teams emphasize skill development and support in natural settings. Fully integrated ACT teams include vocational services that enable clients to find and keep jobs in integrated work settings.

Treatment Episode

❖ Time-unlimited services

Program does not have arbitrary time limits for clients admitted to the program. The ACT team remains the point of contact for all clients indefinitely as needed. Clients often regress when they are terminated from short-term programs. Time-unlimited services encourage the development of stable, ongoing therapeutic relationships. In the past ACT was seen as a life long program for each consumer. However, the fact that people can recover from affects of debilitating symptoms of severe mental illness due to advancements in medication efficacy and recovery oriented community-based treatments, such as ACT, life-long ACT treatment is no longer the philosophy of contemporary ACT Teams. On average, recovery-oriented ACT Teams serve each for 5 years.

❖ Intensity of service

High amount of face-to-face service time as needed in order to help clients with severe and persistent symptoms maintain and improve their function within the community. ACT teams are highly invested in their clients, and maintain frequent contact in order to provide ongoing, responsive support as needed. Frequent contacts are associated with improved client outcomes. The Substance Abuse and Mental Health Services Administration (SAMHSA) recommends the Dartmouth Assertive Community Treatment Scale (DACTS) to measures ACT fidelity. Depending on state requirements for fidelity, the frequency and intensity of services may be higher or lower than the following, which is optimal per the DACTS:

- Frequency of contact: On average 4 or more face to face contacts per week, per consumer.
- Intensity of Service: On average 2 hours of face to face contacts per week per consumer, unless the person is transitioning to a lower level of care.

Intended Outcomes

- Decreased psychiatric hospitalization admissions and subsequent days of utilization
- Decreased jail time
- Increased employment and retention
- Increased housing stability

Other

- Quadrant Model: High Psychiatric/Low Substance Use or High Psychiatric/High Substance use
- Primarily for adults in the Precontemplation or Contemplation Stage of Changes. The treatment matched approach is focused on 1) Outreach; 2) Building a Trusting Relationship; 3) Practical Support; 4) Assessment; 5) Education; and 6) Motivational Interventions such as Motivational Interviewing in order to encourage change.
- LOCUS: Level 4

Additional evidence-based practices that can be blended with ACT include

- Family Psychoeducation
- Integrated Dual Disorder Treatment
- Supported Employment
- Dialectical Behavior Therapy or Cognitive Behavioral Therapy
- Illness Management & Recovery

Resources

Consumer Operated Drop in Center

Support or Service

Consumer Operated Drop-In Center

Targeted Case Cohort

Adults with serious and persistent mental illness and co-occurring substance use disorders

Best Practice Classification

Value Based Practice

Brief Description:

Consumer Operated Drop-In Centers provide an informal, supportive environment to assist consumers with mental illness in the recovery process. Drop-In Centers provide opportunities to learn and share coping skills and strategies, to move into more active assistance and away from passive consumer roles and identities, and to build and/or enhance self-esteem and self-confidence.

❖ Support Groups

Drop-In Centers provide organized support groups or peer-to-peer counseling. This is indicative of the origins and basis for the consumer/survivor self-help movement-grass-roots self-help groups. Drop-In Centers may be specifically designed to assist in the organizing of local support groups in their region or State. This model helps to address the need for peer support, socialization, and recovery-based approaches that emphasize self-determination, consumer/survivor strengths, encouragement, and hope.

❖ Information and Referral

The information and referral component addresses human and social service needs. These services help consumers to understand and access services and benefits which may be available to them.

❖ Information Dissemination

Another key component of a Drop-in Center is providing information and education to the public about their projects, mental health issues, stigma, etc. A number indicated that they focused on addressing the topic of stigma.

❖ **Advocacy**

Advocacy for rights protection and service access is a key component of effective Drop-In Centers. While a variety of advocacy strategies can be employed, the facilitation of consumer representation on boards and committees can be a powerful accomplishment of many of programs.

❖ **Outreach**

Outreach activities include outreach to individuals in hospitals, in-home outreach to provide support services to consumers released from such settings, and street and shelter outreach to consumers experiencing homelessness.

❖ **Technical Assistance and Training**

Technical assistance and training activities to other consumers range from providing training on medication issues to providing technical assistance in other communities to help replicate these projects.

❖ **Independent Living**

Direct services to assist consumers living independently range from shower facilities, to roommate matching services, to small loan funds for housing or employment expenses.

❖ **Employment**

Staff of the Drop-In Center employs consumers in various capacities. Consumer employees provide valuable experience for the individuals involved. Often, it enabled individuals to cease receiving Social Security and other benefits and become fully employed, tax-paying citizens. Consumer staff may use these positions as "stepping stones" to obtain other employment.

❖ **Other**

Other Drop-In Center components may include programs that provide support and skills for consumer's informal support network (i.e., persons not paid to support client, such as family, landlord, shelter staff, employer or other key person), developing and maintaining community support further enhances client's integration and functioning, and developing consumer-run businesses and a video production enterprise (Colorado and Vermont).

Staffing

Drop-in Centers employ consumer staff and recruit consumer volunteers to participate in Drop-in activities. According to the *Consumer/Survivor-Operated Self-Help Programs*:

A Technical Report, U.S Department of Health and Human Services, Substance Abuse and Mental Health Services Administration Center for Mental Health Services, the average cost of a Drop-in Center is \$124,000 per year (Van Tosh & del Vecchio, 2000). The University of Michigan School of Social Work, Ann Arbor 48109-1106 study, included a survey of 32 Drop-in Centers and reported Drop-ins can serve a diverse array of consumers at an average cost of about dollar 8 daily per person and can support up to 200 “members” (Holter & Mowbray, 2005).

Cost drivers include initial startup costs for development of a consumer board and operating procedures, equipment such as a phone and computer, kitchen supplies, office supplies, rent and utilities, and furnishings. The ongoing operation is sustained through payments for membership or by consumer visit to the center. Many drop-ins hire a part-time director and pay stipends to consumers who perform volunteer work at the center. Drop-Ins hold fundraisers and accept donations that help sustain the ongoing operation beyond membership fees.

Treatment Episode

Drop-in Centers are time unlimited and the frequency of attendance is variable. Consumers decide the length and frequency of their participation.

Intended Outcomes

- Decreased psychiatric hospitalization admissions and subsequent days of utilization
- Increased employment and retention
- Increased housing stability

A participatory evaluation of the NYAPRS Peer Bridger Project conducted by Cheryl MacNeil, Ph.D. examined benefits of peer services including temporary relief from social isolation often experienced by people who are hospitalized and the ability to share with each other wisdom and survival skills necessary for the process of recovery. The most substantial finding was that follow-up re-hospitalization rates during a two year period decreased from 60% to 19%, an improvement of 41% for individuals who were recipients of peer provided bridging services (Rosenthal, 1998a). Over 70% of self-help groups report their members stay out of the hospital, hold a job and are living more independently and assuming more responsibility (Rosenthal, 1998b).

Other

- Quadrant Model: High Psychiatric/Low Substance Use or High Psychiatric/High Substance use
- Primarily for adults in the Contemplation, Action, or Maintenance Stages of Changes
- LOCUS: Level 1-4

Additional evidence-based practices that can be blended with Drop-in Center include

- Wellness Recovery Action Planning (WRAP)
- Illness Management & Recovery

Resources

Consumer/Survivor-Operated Self-Help Programs: A Technical Report, U.S Department of Health and Human Services, Substance Abuse and Mental Health Services Administration Center for Mental Health Services

Crisis Stabilization Services

Support or Service

Crisis Stabilization Services (CSS)

Targeted Case Cohort

Adults with serious and persistent mental illness and co-occurring substance use disorders and their supporters.

Best Practice Classification

Best Practice

Brief Description

Crisis Stabilization Services (CSS) are a growing alternative for individuals experiencing a psychiatric or mental health emergency to jails and inpatient hospitalizations/emergency departments (Day, Hyde, Mulkern & O'Brien, 2005). CSS include a variety of services and options for individuals experiencing mental health and psychiatric crises. They include: 24-hour crisis telephone lines, walk-in crisis services, mobile crisis services, crisis residential/crisis respite services, and crisis stabilization units (Day, et al., 2005). These community-based services are an alternative to hospital- and institution-based services, which are less expensive, but have similar outcomes (Day, et al., 2005; Adams & El-Mallakh, 2009).

❖ 24-Hour Crisis Telephone Lines

The telephone is often the first point of contact with the crisis system for a person in crisis or a member of his/her support system. Telephone crisis services should be available 24 hours per day to provide assessment, screening, triage, preliminary counseling, information, and referral services. A primary role of telephone crisis personnel is to assess the need for face-to-face crisis intervention services and to arrange for such services when and if indicated. Warm lines are designed to provide social support to callers in emerging, but not necessarily urgent, crisis situations. Peer-run warm lines are a relatively new pre- and post-crisis service. Peers are current or former consumers of services who are trained to provide non-crisis supportive counseling to callers.

Warm lines focus on the following:

- (1) Building peer support networks and establishing relationships,
- (2) Active listening and respect for consumer boundaries, and
- (3) Making sure callers are safe for the night (Day, et al., 2005).

❖ **Walk-in Crisis Services**

Walk-in crisis services are provided through Urgent Care Centers in some communities. Services typically include:

- (1) Screening and assessment;
- (2) Crisis stabilization (including medication);
- (3) Brief treatment; and
- (4) Linking with services.

Single or multiple community agencies may be identified to address walk-in crisis and "urgent" situations on a 24-hour basis or through extended service hours (Day, et al., 2005).

❖ **Mobile Crisis Services**

Mobile Crisis Services involve teams that have the capacity to intervene quickly, day or night, wherever the crisis is (e.g., homes, emergency rooms, police stations, outpatient mental health settings, schools, etc.). These teams can serve persons unknown to the system and often work closely with the police, crisis hotlines, and hospital emergency services personnel. Mobile teams can operate out of a wide variety of locations, either centralized or distributed throughout the community. Although some mobile crisis teams may specialize in serving adults or children exclusively, it is important to note that these teams often become involved in treating the entire family or other support system. Thus, an "extended intervention," which can include short-term counseling, may be necessary. In this instance, a mobile team member may act as the primary care provider until it is appropriate to transition the family into mainstream services. Some mobile teams may have broad authority and responsibilities for service management that include, but are not limited to:

- (1) Providing pre-screening assessments or acting as gatekeepers for inpatient hospitalization of consumers utilizing public services; and
- (2) Managing and controlling access to crisis diversionary services.

In designing mobile crisis teams, it is critical to remember that what these teams do is far more important than the specific logistics of their operation. Some mobile teams operate 24 hours a day, whereas others operate only during nights and weekends, relying on community agencies or walk-in centers to handle crises during regular working hours. In some systems, mobile teams provide preventive support in the form of "wellness checks" for persons felt to be fragile or at risk. While one of the goals of a mobile crisis team is to link consumers to community support services, teams vary in their capacity to accomplish this task. Clear channels of access that are established between the team and community programs prior to team operations greatly enhance this effort (Day, et al., 2005).

❖ **Crisis Residential/Crisis Respite**

On occasion, resolution of a crisis may require the temporary removal of a consumer from his or her current environment. The purpose of crisis respite/residential services is

to provide the individual in crisis with support in a calm, protected, and supervised non-hospital setting. During this period, the person can stabilize, resolve problems, and link with possible sources of ongoing support. A range of settings for residential/respite crisis support should be available to meet the varying needs and desires of individuals. Residential supports can be classified as either individual or group.

Individual Residential Supports

Individual approaches serve one or two persons in a particular setting. Examples include **family-based crisis homes** where the person in crisis lives with a screened and trained “professional family.” In addition to practical and emotional support from “family” members, professional providers visit the home daily to help the consumer develop a self-management treatment plan and connect with needed services. A **crisis apartment** is another model of providing individual support. In a crisis apartment, a roster of crisis workers or trained volunteer staff provide 24-hour observation, support, and assistance to the person in crisis who remains in the apartment until stabilized and linked with other supports. In a **peer support** model, groups of consumers look after the person in crisis in the home of one of their members providing encouragement, support, assistance, and role models in a non-threatening atmosphere. Finally, an **in-home support** approach, similar to a crisis apartment but in the person’s own residence, can be considered if separation from the natural environment is not felt to be necessary. A similar range of services as described in the family-based peer model above are available to consumers in their own home.

Group Residential Supports

Group respite/residential approaches have the capacity to serve more than two consumers at a time. These services are generally provided through crisis residences that combine two types of assistance – crisis intervention and residential treatment. **Crisis residences** offer short-term treatment, structure, and supervision in a protective environment. Services depend on the program philosophy, but can include physical and psychiatric assessment, daily living skills training, and social activities, as well as counseling, treatment planning, and service linking. Crisis residential services are used primarily as an alternative to hospitalization, but can also shorten hospital stays by acting as a step-down resource upon hospital discharge (Day et al., 2005).

❖ Crisis Stabilization Units

Crisis Stabilization Unit services are provided to individuals who are in psychiatric crisis whose needs cannot be accommodated safely in the residential service settings previously discussed. CSUs can be designed for both voluntary and involuntary consumers who are in need of a safe, secure environment that is still less restrictive than a hospital. The goal of the CSU is to stabilize the consumer and re-integrate him or her back into the community quickly. The typical length of stay in a CSU is less than five days. Consumers in CSUs receive medication, counseling, referrals, and linkage to

ongoing services. Multi-disciplinary teams of mental health professionals staff CSUs, which generally cost two-thirds the amount of a daily inpatient stay.

23-Hour Beds

Twenty-three hour beds, also known as Extended Observation Units (EOUs), may be found in some communities as a stand-alone service or embedded within a CSU. Twenty-three hour beds and EOUs are designed for consumers who may need short, fairly intensive treatment in a safe environment that is less restrictive than hospitalization. This level of service is appropriate for individuals who require protection when overwhelmed by thoughts of suicide or whose ability to cope in the community is severely compromised. Admission to 23-hour beds is desirable when it is expected that the acute crisis can be resolved in less than 24 hours. Services provided include administering medication, meeting with extended family or significant others, and referral to more appropriate services.

❖ Admission Criteria

Admission criteria depend on the training and backgrounds of staff involved. However, criteria may include, but is not limited to any of the following:

- (1) Individual is a danger to him/herself or others
- (2) Individual is in an active state of psychosis
- (3) Individual is arrested/detained by law enforcement for behavior related to psychosis

Staffing

24-hour telephone crisis lines may be staffed by an individual who has received some kind of training in crisis deescalation and motivational interviewing. Peer supports are encouraged for this service. Other services listed should be staffed by a licensed prescriber, a registered nurse, a case manager, and a licensed therapist or counselor.

Treatment Episode

CSS are short-term and typically should last less than five days. However, referral and follow-up services should be offered to ensure individual's are connected to appropriate services and able to follow through with treatment plans.

Intended Outcomes

- Decreased psychiatric hospitalization admissions and subsequent days of utilization
- Decreased jail time
- Increase the linkages to appropriate/needed services

Other

- Quadrant Model: High Psychiatric/Low Substance Use; Low Psychiatric/High Substance Use; and High Psychiatric/High Substance use
- Any Stage of Changes.
- LOCUS: Level 3, 4, 5, and 6
- Can serve as entry point to additional, long-term interventions

Resources

[Core Elements in Responding to Mental Health Crisis](#)

Practice guidelines developed by SAMHSA outlining recovery-oriented approaches to dealing with mental health crises.

[A Community-Based Comprehensive Psychiatric Crisis Response Service](#)

A useful report from the Technical Assistance Collaborative, 2005 (134pages)

[Report and Recommendations Regarding Psychiatric Emergency and Crisis Services](#)

This report by the American Psychiatric Association Task Force on Psychiatric Emergency Services reviews and provides details on model programs Published in 2002.(101 pages)

Family Psychoeducation

Support or Service

Family Psychoeducation Multi-family Group (FPE)

Targeted Case Cohort

Adults with serious and persistent mental illness and co-occurring substance use disorders and their supporters.

Best Practice Classification

Evidenced Based Practice

Brief Description

Family Psychoeducation (FPE) is an evidence-based psychiatric rehabilitation practice that aims to achieve the best possible outcome for consumers with serious mental illness (SMI) through collaborative treatment between practitioners and family members of the individual with SMI. Additionally, FPE attempts to alleviate the stress experienced by family members by supporting them in their efforts to aid the recovery of their loved one. Research has demonstrated that FPE results in a 20% - 50% reduction in relapse and re-hospitalization rates among consumers whose families received psychoeducation than among those receiving standard individual services (Lam, Knipers & Leff, 1993; Penn & Mueser, 1996; Falloon, Held et al., 1999). Moreover, families that receive education and support feel less burden and are more effective at helping their loved ones with SMI to manage their illnesses (Dixon & Lehman, 1995). Family Psychoeducation (FPE) practitioners develop a working alliance with consumers and families. FPE is not family therapy. In family therapy, the family itself is the object of treatment. But in the FPE approach, the illness is the object of treatment, not the family.

FPE is an approach for partnering with consumers and families to treat serious mental illnesses. FPE can be delivered in the mental health center, community location, or Partial Hospital Program. The goal is that practitioners, consumers, and families work together to support recovery. FPE services are provided in three phases: 1) Joining sessions; 2) An educational workshop; and 3) Ongoing FPE sessions.

❖ Joining Sessions

Initially, FPE practitioners meet with consumers and their respective family members in introductory meetings called joining sessions. The purpose of these sessions is to learn

about their experiences with mental illnesses, their strengths and resources, and their goals for treatment. FPE practitioners engage consumers and families in a working alliance by showing respect, building trust, and offering concrete help. This working alliance is the foundation of FPE services. Joining sessions are considered the first phase of the FPE program.

❖ **Educational Workshop**

In the second phase of the FPE program, FPE practitioners offer a 1-day educational workshop. The workshop is based on a standardized educational curriculum to meet the distinct educational needs of family members. FPE practitioners also respond to the individual needs of consumers and families throughout the FPE program by providing information and resources. To keep consumers and families engaged in the FPE program, it is important to tailor education to meet consumer and family needs, especially in times of crisis.

❖ **Ongoing FPE Sessions**

After completing the joining sessions and 1-day workshop, FPE practitioners ask consumers and families to attend ongoing FPE sessions. When possible, practitioners offer ongoing FPE sessions in a multifamily group format. Consumers and families who attend multifamily groups benefit by connecting with others who have similar experiences. The peer support and mutual aid provided in the group builds social support networks for consumers and families who are often socially isolated. Ongoing FPE sessions focus on current issues that consumers and families face and address them through a structured problem-solving approach. This approach helps consumers and families make gains in working toward consumers' personal recovery goals. FPE is not a short-term intervention. Studies show that offering fewer than 10 sessions does not produce the same positive outcomes (Cuijpers, 1999). We currently recommend providing FPE for 9 months or more. FPE is based on six principles:

- ✓ Consumers define who their family is;
- ✓ The practitioner-consumer-family alliance is essential;
- ✓ Education and resources help families support consumers' personal recovery goals;
- ✓ Consumers and families who receive ongoing guidance and skills training are better able to manage mental illnesses;
- ✓ Problem solving helps consumers and families define and address current issues; and
- ✓ Social and emotional support validates experiences and facilitates problem solving.

❖ **Admission Criteria**

The greatest amount of research has shown benefits for consumers with schizophrenic disorders and their families (Dixon et al., 2001). Studies also show promising results with Bipolar Disorder, Major Depressive Disorder, Obsessive Compulsive Disorder, and Borderline Personality Disorder. Consumers must have willing natural supporters (e.g. family, friends, etc.) in order to receive FPE.

Staffing

FPE is best delivered by practitioners that work with the consumer as part of the interdisciplinary team; not brokered outside the team. Practitioner credentials are, at minimum, a bachelor degree. When offering FPE in the multifamily group format, designate two FPE practitioners to facilitate each group. The recommended size of a FPE multifamily group is five to eight consumers. The two practitioners work with existing consumers from their existing caseloads. As an alternative, a trained family mentor can co-facilitate with a professional. If the organization intends to offer FPE throughout the organization, a full-time FPE coordinator is recommended.

Treatment Episode

FPE is provided for a minimum of 9 Months of on-going sessions which occur twice per month.

Intended Outcomes

- Decreased psychiatric hospitalization admissions and subsequent days of utilization
- Decreased jail time
- Decrease crisis intervention contacts
- Increased employment and retention

Implementing an FPE program has initial costs related to training and program development. However, studies show a low cost-benefit ratio related to savings from reduced hospital admissions, hospital days, and crisis intervention contacts (McFarlane, Dixon, Lukens, & Lucksted, 2003). Cost-benefit ratios vary by state. For example, in New York, for every \$1 in costs for FPE provided in a multifamily group format, a \$34 savings in hospital costs occurred during the second year of treatment (McFarlane, 2002). In a hospital setting in Maine, an average net savings occurred of \$4,300 per consumer each year over 2 years. Ratios of \$1 spent for this service to \$10 in saved hospitalization costs were routinely achieved. Non-fiscal savings are achieved as complaints from families about services decrease and family support for the agency and the mental health authority grows. In many communities, this has translated into political support for funding for expanded and improved services.

Other

- Quadrant Model: High Psychiatric/Low Substance Use or High Psychiatric/High Substance use

- Primarily for adults in the Precontemplation or Contemplation Stage of Changes. The treatment matched approach is focused on 1) Outreach; 2) Building a Trusting Relationship; 3) Practical Support; 4) Assessment; 5) Education; and 6) Motivational Interventions such as Motivational Interviewing in order to encourage change.
- LOCUS: Level 3, 4, and 5

Additional evidence-based practices that can be blended with FPE include

Family-to-Family Education Program (FFEP): A self-help and empowerment approach with family-member outcomes as its primary focus (e.g., increase understanding of mental illness, reduce stress) and consumer well-being as an intermediary or secondary goal (e.g. through better communication or family atmosphere). FFE is created and led by family members of people with mental illnesses.

Resources

Substance Abuse and Mental Health Services Administration. *Family Psychoeducation: Building Your Program*. HHS Pub. No. SMA-09-4422, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2009.

Illness Self-Management & Recovery

Support or Service

Illness Management & Recovery

Targeted Case Cohort

Adults with serious and persistent mental illness and co-occurring substance use disorders and their supporters.

Best Practice Classification

Evidenced Based Practice

Brief Description

Illness Management & Recovery is a broad set of strategies designed to help individuals with serious mental illness collaborate with professionals in managing their mental illness, reduce their susceptibility to the illness (e.g., relapses, effects on functioning), and to cope effectively with their symptoms. Recovery is what occurs when people with a mental illness discover (or rediscover) their strengths and abilities for pursuing personal goals and develop a sense of identity that allows them to grow beyond their mental illness (Mueser, et al., 2002). Therefore, Illness Management & Recovery focus on minimizing symptoms and relapses, and help people develop and pursue their personal goals (Mueser, et al., 2002).

❖ Broad-Based Psychoeducation Programs

Most of these programs provide information to people about mental illness, including symptoms, the stress-vulnerability model, and treatment (Mueser, et al., 2002). Research indicates that psychoeducation groups increased participant knowledge about mental illness, and mixed results on taking medication as prescribed (Mueser, et al., 2002). Groups typically last eight sessions and follow-up periods can range from ten days to two years (Mueser, et al., 2002).

❖ Medication-Focused Programs

Medication-focused programs typically utilize either a psychoeducational approach or cognitive-behavioral approaches, or a combination (Mueser, et al., 2002). Psychoeducational programs typically include one to two sessions with a curriculum surrounding medication information, benefits, side effects, strategies to manage side effects, and the importance of taking medication as prescribed (Mueser, et al., 2002).

Research demonstrated an increased knowledge in participants' regarding their medications, but had mixed results in terms of continued taking medications as prescribed (Mueser, et al., 2002). Cognitive-behavioral approaches typically focus on employing one of the following techniques: behavioral tailoring, simplifying the medication regimen, motivational interviewing, or social skills training. Behavioral tailoring programs involve working with people to develop strategies for incorporating medication into their daily routine. Simplifying the medication regimen may involve taking the medication once or twice a day, instead of more often. Motivational interviewing involves helping people articulate personally meaningful goals and exploring how medication may be useful in achieving those goals. Finally, social skills training focuses on teaching skills to improve interactions with prescribers, such as how to discuss medication side effects (Mueser, et al., 2002). Research supports strategies of behavioral tailoring in increasing participants' taking medication as prescribed (Mueser, et al., 2002). One study also demonstrated that a broad-based cognitive-behavioral program reported lower rates of rehospitalization (Mueser, et al., 2002).

❖ **Relapse Prevention**

Relapse prevention programs focus on teaching people how to recognize environmental triggers and early warning signs of relapse, and taking steps to avert further symptom exacerbations (Mueser, et al., 2002). Programs also focus on stress management skills. Family members may be included in these groups to help individuals' develop full awareness. Research indicates that teaching the early warning signs of relapse was associated with better outcomes, including fewer relapses and rehospitalizations, and lower treatment costs (Mueser, et al., 2002). Family interaction has also been demonstrated to have a higher rate of success in preventing relapses (Mueser, et al., 2002).

❖ **Coping Skills Training and Comprehensive Programs**

Coping programs aim at increasing the ability to deal with symptoms and stress or persistent symptoms, while comprehensive programs incorporate a broad array of illness management strategies, including psychoeducation, relapse prevention, stress management, teaching coping strategies, and goal setting and problem solving (Mueser, et al., 2002). Coping skills programs that employed cognitive-behavioral techniques, produced uniformly positive results in reducing symptom severity (Mueser, et al., 2002). Comprehensive programs were shown to be effective at improving outcomes with individuals with Schizophrenia (Mueser, et al., 2002).

❖ **Cognitive-Behavioral Treatment of Psychotic Symptoms**

Cognitive-behavioral approaches to psychosis include teaching coping skills, such as distraction techniques to reduce preoccupation with symptoms, and the modification of dysfunctional beliefs about the illness, the self, or the environment (Mueser, et al., 2002). Cognitive-behavioral approaches have been shown to reduce the severity of

psychotic symptoms, as well as decrease the occurrence of negative symptoms, such as social withdrawal and anhedonia (Mueser, et al., 2002).

❖ **Admission Criteria**

The greatest amount of research has shown benefits for consumers with schizophrenic disorders and their families (Mueser, et al., 2002). Family members are considered essential to managing mental illness. Peer-led groups are also being developed. Other research continues to focus on broadening and solidifying the results of Illness Management & Recovery.

Staffing

Illness Management & Recovery is best delivered by practitioners that work with the individual as part of the interdisciplinary team; not brokered outside the team. Practitioner credentials are, at minimum, a bachelor degree. However, there are roles to play for family members and peer-supports. When offering aspects of Illness Management & Recovery in a group format, designate two practitioners to facilitate. The recommended size of a psychoeducation group is five to eight consumers. The two practitioners work with existing consumers from their existing caseloads. As an alternative, a trained family mentor or peer-support can co-facilitate with a professional.

Treatment Episode

Broad-based psychoeducation programs typically last eight sessions over a 1 – 3 month time period. Medication-focused programs typically last one to two sessions. Relapse prevention programs typically last 3 – 6 months, meeting weekly. Coping skills training and comprehensive programs typically last 2 – 3 months, meeting weekly. Cognitive-behavioral treatment of psychotic symptoms varies with each individual.

Intended Outcomes

- Decreased psychiatric hospitalization admissions and subsequent days of utilization
- Decreased jail time
- Decrease crisis intervention contacts
- Increased employment and retention
- Improved quality of life

Implementing an Illness Management & Recovery program has initial costs related to training and program development. However, studies show a low cost-benefit ratio related to savings from reduced hospital admissions, hospital days, and crisis intervention contacts (Mueser, et al., 2002). Non-fiscal savings are achieved as complaints from families about services decrease and family support for the agency and the mental health authority grows. In many communities, this has translated into political support for funding for expanded and improved services.

Other

- Quadrant Model: High Psychiatric/Low Substance Use or High Psychiatric/High Substance use
- Primarily for adults in the Precontemplation or Contemplation Stage of Changes. The treatment matched approach is focused on 1) Outreach; 2) Building a Trusting Relationship; 3) Practical Support; 4) Assessment; 5) Education; and 6) Motivational Interventions such as Motivational Interviewing in order to encourage change.
- LOCUS: Level 3, 4, and 5

Additional evidence-based practices that can be blended with Illness Management & Recovery include

- Family Psychoeducation Programs
- Peer Support
- Partial Hospitalization
- Integrated Dual Diagnosis Treatment
- Supported Employment

Resources

Intergraded Dual Disorder Treatment Team

Support or Service

Integrated Dual Disorder Treatment (IDDT)

Targeted Case Cohort

Adults with serious and persistent mental illness and co-occurring substance use disorders and their supporters.

Best Practice Classification

Evidenced Based Practice

Brief Description

As described by Ohio's Substance Abuse and Mental Illness Coordinating Center of Excellence (Ohio SAMI CCOE), the SAMHSA endorsed Integrated Dual Disorder Treatment (IDDT) model is an evidence-based practice that improves the quality of life for people with co-occurring severe mental and substance addiction by combining substance abuse services with mental health services. It helps people address both disorders at the same time—in the same service organization by the same team of treatment providers (Delos Reyes, et al., 2008). IDDT is multidisciplinary and combines pharmacological (medication), psychological, educational, and social interventions to address the needs of consumers and their family members. IDDT also promotes consumer and family involvement in service delivery, stable housing as a necessary condition for recovery, and employment as an expectation for many. Treatment is individualized to address the unique circumstances of each person's life. IDDT promotes ongoing recovery from co-occurring disorders by providing service organizations with specific strategies for delivering services.

❖ Multidisciplinary Team

The IDDT model views all activities of life as part of the recovery process. Therefore, a variety of service providers help each consumer in all aspects of life. The multidisciplinary treatment team meets regularly to discuss each consumer's progress in all areas of his or her life and to provide insights and advice to one another. Team members also meet individually and as a group with each consumer and their caregivers (family, friends, and other supporters) to discuss the consumer's progress and goals. Successful IDDT programs coordinate all aspects of recovery to ensure that consumers, caregivers, and service providers are working toward the same goals in a collaborative manner. The service team consists of the following:

- ✓ Team leader;
- ✓ Nurse Case manager;
- ✓ Employment specialist;
- ✓ Substance abuse specialist;
- ✓ Housing specialist;
- ✓ Counselor;
- ✓ Criminal justice specialist; and
- ✓ Physician/psychiatrist

❖ **Stage-Wise Interventions**

Research suggests that individuals with co-occurring disorders gain the most confidence with their abilities to recover or develop independent living skills and to meet daily living needs when they experience incremental successes through stages of personal change. With an understanding of these stages, caregivers (family and friends) and service providers are best equipped to help persons with co-occurring disorders recover and maintain their self-confidence and independence. The IDDT model stresses that caregivers and service providers should utilize the four stages of treatment in **Appendix XX** to guide every interaction with individuals who have dual disorders.

❖ **Access to Comprehensive Services**

Successful IDDT programs offer comprehensive services because the recovery process occurs in the context of daily living. Services are available to meet the needs of consumers in all stages of treatment. Below is a list of comprehensive services:

- ✓ Case management (Intensive Case Management or ACT)
- ✓ Family services
- ✓ Integrated substance abuse treatment (mental health/substance use counseling)
- ✓ Medical services
- ✓ Housing/residential supports
- ✓ Supported employment

❖ **Time Unlimited Services**

Consumers with co-occurring disorders do not experience recovery in a straight line. Relapse is a function of recovery which may last throughout their lives. In addition, consumers will achieve the highest quality of life when they have access to services all the time. Therefore, the IDDT model encourages organizations to provide services to consumers throughout the lifespan, even when symptoms are mild and/or infrequent. The IDDT model also encourages organizations not to discharge consumers from treatment if they stop taking their medication or continue using alcohol or other drugs. Setbacks like these may occur naturally as part of a lifelong cycle of relapse and recovery.

❖ **Assertive Outreach**

Successful IDDT programs utilize assertive outreach to keep consumers engaged in relationships with service providers, family members, and friends. Service providers who utilize assertive outreach meet with consumers in community locations that are familiar to consumers, such as in their homes or at their favorite coffee shops or restaurants. Service providers meet regularly with consumers and offer practical assistance with daily needs and living skills. This frequent and helpful interaction enables them to develop trust and a working alliance with consumers. Service organizations that utilize the IDDT model engage in assertive outreach with all of their consumers, whether symptoms are severe or mild. They especially meet with those who are in the engagement stage of treatment.

❖ **Motivational Interviewing**

Motivational interviewing is a technique that helps consumers identify their goals and individualized strategies to meet their goals. The technique examines consumers' ambivalence about their goals and strategies. This process enables consumers to develop discrepancy and understand the relationship between what they want in life and what keeps them from achieving their goals. Motivational interviewing includes the following:

- ✓ Expressing empathy
- ✓ Avoiding argumentation
- ✓ Rolling with resistance
- ✓ Encouraging self-confidence and hope
- ✓ Developing discrepancy between goals and current lifestyle/behaviors
- ✓ Acknowledging accomplishments and incremental changes

❖ **Substance Abuse Counseling**

Once consumers are motivated to manage their illnesses, they are ready to develop skills to control symptoms and to pursue healthy lifestyles. Counseling may take place in individual, group, or family settings. Consumers who are in the active-treatment stage or relapse prevention stage receive substance abuse counseling.

❖ **Group Treatment**

Consumers with co-occurring disorders achieve better outcomes when they engage in stage-wise group treatment that addresses both disorders and promote peer supports. In groups, consumers share their experiences and learn effective coping strategies from each other. Service organizations using the IDDT model should offer a menu of group treatment options to all consumers who experience co-occurring disorders. They should engage approximately two-thirds of these consumers regularly (e.g., at least weekly) in a range of stage-wise group treatments.

❖ **Family Psychoeducation**

Supporting and communicating with care givers and supporters of the consumer are critical to both the recovery of consumers. The IDDT team members encourage partnerships among consumers, supporters/caregivers and also reduce stress so that the relationships can be maintained- or is often the situation to rebuild relationships. Research has shown that family psychoeducational programs can be a powerful approach for improving substance abuse outcomes. It is also recommended that IDDT Teams develop relationships with their local Alliance for the Mentally Ill and refer families to the organization through these representatives.

❖ **Participation in Alcohol and Drug Self Help Groups**

Social supports are critical to reducing relapse for consumers with co-occurring disorders. Self-help groups provide consumers with opportunities to share and learn from others who experience dual disorders. Clinicians should connect consumers who are in the active-treatment and relapse-prevention stages with substance abuse self-help programs in the community.

❖ **Pharmacological Treatment**

Psychotropic medications are effective in the treatment of persons with severe mental illness and co-occurring disorders. However, medications alone are not effective. Physicians work as part of a comprehensive approach and are trained in dual disorder treatment to increase medication adherence.

❖ **Interventions to Promote Health**

Research indicates that individuals with co-occurring disorders are at increased risk for poor health (e.g. emergency services, hospitalization, infectious diseases, chronic illnesses, suicide, exposure to violence, etc.). Consumers are encouraged to live healthy lifestyles through learning to eat nutritious meals, avoid high risk situations (e.g. sex, victimization, etc.).

❖ **SECONDARY INTERVENTIONS FOR NON-RESPONDERS TO SUBSTANCE ABUSE TREATMENT**

Not all consumers respond to treatment. Secondary interventions must be in place that include increased monitoring of medications, use of state laws that allow for payeeships and Assisted Outpatient Treatment (i.e. in Michigan, Kevin's Law). Long-term residential should be available and utilized as a last resort.

Staffing

When combined with Assertive Community Treatment, the staffing of IDDT and ACT is virtually identical. However, IDDT can be delivered through an Intensive Case

Management Model where case load sizes are one case manager to 25-30 consumers. Case managers work as a team so that consumers can be shared when necessary. There are no established staffing patterns for IDDT through an Intensive Case Management Model as the needs of the consumers are highly variable. For instance, co-occurring therapy is available for consumers in the preparation through maintenance stages of change, but is not particularly useful for consumers in the precontemplation stage of change. However, an example of staffing for the majority of consumers may look something like:

- ✓ Program Leader: Dedicated full-time to IDDT and fulfills both an administrative and clinical role;
- ✓ Case Manager: 1:25 staff to consumer ratio with 2 hours per week per consumer
- ✓ Nurse: 1 hour per month per consumer
- ✓ Psychiatry: 1 hour per month per consumer
- ✓ Co-occurring Therapist: 1 hour per week per consumer
- ✓ Employment Specialist: 1 hour per week per consumer

Treatment Episode

IDDT is time-unlimited as it an approach for adults with severe mental illness and co-occurring substance use and addiction disorders that are likely to struggle with their recovery for their lifetime.

Intended Outcomes

- ✓ Improvement in psychiatric symptoms and functioning;
- ✓ Decreased hospitalization;
- ✓ Increased housing stability;
- ✓ Fewer arrests; and
- ✓ Improved quality of life (Drake et al., 2001).

Other

- Quadrant Model: High Psychiatric/High Substance Use
- Primarily for adults in the Precontemplation or Contemplation Stage of Changes. The treatment matched approach is focused on 1) Outreach; 2) Building a Trusting Relationship; 3) Practical Support; 4) Assessment; 5) Education; and 6) Motivational Interventions such as Motivational Interviewing in order to encourage change.
- LOCUS: Level 3, 4, and 5

Additional evidence-based practices that can be blended with IDDT include

- ✓ Family Psychoeducation
- ✓ Wellness Management and Recovery
- ✓ Assertive Community Treatment
- ✓ Supported Employment

Resources

Substance Abuse and Mental Health Services Administration. *Integrated Treatment for Co-Occurring Disorders: Building Your Program*. DHHS Pub. No. SMA-08-4366, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2009.

Partial Hospital Program

Support or Service

Partial Hospital Program (PHP)

Targeted Case Cohort

Adults with serious and persistent mental illness and co-occurring substance use disorders

Best Practice Classification

Not an evidence-based practice

Brief Description

Partial hospitalization is a type of program used to treat mental illness and substance use. In partial hospitalization, the patient continues to reside at home, but commutes to a treatment center up to seven days a week. Since partial hospitalization focuses on overall treatment of the individual, rather than purely safety, the program is not used for acutely suicidal people.

Partial hospital programs result from the movement to deinstitutionalize chronic mental health patients. This was thought to be a way to provide a better living environment in a less restrictive setting for the patient and a way to reduce the cost of long-term care.

Partial hospitalization should not be confused with day treatment which is sometimes referred to as partial hospitalization. Partial hospitalization is provided on or in affiliation with a hospital. This separates them from partial care or day treatment which are either non-profit or profit agencies not affiliated with a hospital. Treatment during a typical day may include assessment, group therapy, individual therapy, and psychopharmacology.

Programs are available for the treatment of alcoholism and substance use problems, Alzheimer's disease, anorexia and bulimia, depression, bipolar, anxiety disorders, schizophrenia, and other mental illnesses. Programs geared specifically toward geriatric patients, adult patients, adolescents, or young children. Programs for adolescents and children usually include an academic program, to either take the place of or to work with the child's local school.

Currently, many providers are moving away from the partial hospitalization model of day treatment and are adopting a psychosocial rehabilitation (PSR) model instead. The focus of PSR is on patient (or "member," as they are often referred to) empowerment, while seeking to "rehabilitate" patients with chronic mental illness so they can function

more independently in the local community (see Psychosocial Rehabilitation/Club House model for a description of these types of services).

Additionally, some people have objected to the term *partial hospitalization* itself, since hospitalization for mental illness generally seeks to prevent injury to the patient or to those the patient encounters. Many patients in partial hospitalization programs do not, have not, and likely will never be psychiatrically hospitalized. As such, they object to the implication that a partial hospitalization program is "one step away" from actual hospitalization.

Staffing

State hospital licensing laws dictate staffing ratio and patterns.

Treatment Episode

Treatment, services and supports are typically provided for six or more hours per day, five days a week, in a licensed setting. The average length of stay is 5-7 days. The use of partial hospitalization as a setting of care presumes that the patient does not currently need treatment in a 24-hour protective environment. Conversely, the use of partial hospitalization implies that routine outpatient treatment is of insufficient intensity to meet the patient's present treatment needs.

Intended Outcomes

- Decreased psychiatric hospitalization admissions and subsequent days of utilization

Other

- Quadrant Model: High Psychiatric/Low Substance Use or High Psychiatric/High Substance use
- Primarily for adults in the Contemplation or Action Stages of Changes. Motivational Interventions such as Motivational Interviewing in order to encourage change.
- LOCUS: Level 4

Additional evidence-based practices that can be blended with Partial Hospital Program include

- Family Psychoeducation
- Integrated Dual Disorder Treatment
- Dialectical Behavior Therapy or Cognitive Behavioral Therapy

Resources

Peer Support Specialist Services

Support or Service

Peer Support Specialist

Targeted Case Cohort

Adults with serious and persistent mental illness and co-occurring substance use disorders

Best Practice Classification

Value Based Practice

Brief Description

Peer Support Specialists (PSS) are individuals who have a unique background and skill level that is based on their experience with their mental illness as well as use of services and supports to achieve their personal goals of community membership, independence and productivity. PSS have a unique ability to gain the trust and respect of others struggling with the effects of mental illness because of their shared experience and perspectives with recovery, and with planning and negotiating human services systems.

Activities provided by PSS are completed in partnership with consumers for the specific purpose of achieving increased community inclusion and participation, independence and productivity. The PSS for persons with mental illness is available to provide the consumer with information and support at all phases of recovery, from emergency to outpatient or inpatient settings. The PSS performs a wide range of tasks to assist the person in regaining control over their own life and recovery process. The PSS is a role model in recovery and ongoing coping skills.

PSS may be part of a support team and can facilitate some of the activities based on their scope of practice, such as facilitating peer support groups, assisting in transitioning individuals to less intensive services, and by mentoring towards recovery and/or the desired quality of life goals. The role of the PSS is specified in the individual's Supports & Services Plan and is authorized through the Person Centered Planning process.

With appropriate training and experience, Peer Support Specialist provide assistance with the following:

❖ Crisis Support Skills

- ✓ Developing and using a crisis plan;
- ✓ Recognizing relapse signs;
- ✓ Asking for help to avert a crisis;
- ✓ Providing supportive services during crises;

❖ **Education/Employment/Vocational Assistance**

- ✓ Support for seeking education and/or training opportunities;
- ✓ Finding a job;
- ✓ Achieving successful employment activities;
- ✓ Developing self-employment opportunities;
- ✓ Vocational training;
- ✓ Obtaining information about returning to school and/or work
- ✓ Learning about returning to paid part-time or full-time work;
- ✓ Learning about the process to obtain reasonable accommodations;

❖ **Individual Advocacy**

- ✓ Assisting consumers with developing Psychiatric Advance Directives;
- ✓ Developing wellness plans (in a group setting or individually);
- ✓ Learning about and pursuing alternatives to guardianship;
- ✓ Participating in medication reviews with consumers and helping to articulate concerns about medication/diagnosis;
- ✓ Taking a proactive role in recovery;

❖ **Housing Assistance**

- ✓ Locating and acquiring appropriate housing for achieving independent living;
- ✓ Finding and choosing roommates;
- ✓ Utilizing short-term, interim, or one-time-only financial assistance in order to transition from restrictive settings into independent integrated living arrangements;
- ✓ Making applications for Section 8 Housing vouchers;
- ✓ Managing costs of room and board utilizing an individual budget;
- ✓ Assistance with maintaining stable housing;

❖ **Person Center Planning (PCP)**

- ✓ Assisting consumers with PCP pre-planning process;
- ✓ Lead the development of the plan on behalf of a consumer/treatment team if request by the consumer;
- ✓ Offers a unique perspective from their experience with recovery and the person centered planning process;

❖ **Support**

- ✓ One-on-one support or group;
- ✓ Identifying coping strategies for successfully caring for or living with a person with mental illness;

❖ **Self Determination**

- ✓ Applying arrangements that support self-determination,
- ✓ Selecting support staff;

❖ **Self Help**

- ✓ Making informed, independent choices;
- ✓ Building networks of support and information;

❖ **Social Networking**

- ✓ Forming new supportive relationships;
- ✓ Improving relationships with family members;
- ✓ Recognizing unhealthy relationships and how to get out of them;
- ✓ Developing, implementing and providing ongoing guidance for advocacy and support groups;

❖ **System Advocacy**

- ✓ Facilitating, volunteering or working for a cause that the consumer supports,
- ✓ Talking about what it means to have a mental illness,
- ✓ Obtaining information on mental illness and recovery,
- ✓ Assisting with self advocacy
- ✓ Accessing entitlements

❖ **Team Members**

- ✓ Member of treatment teams;
- ✓ Welcoming and providing orientation to the provider organizations;
- ✓ Participating in ACT Teams
- ✓ Member of Mobile Crisis Response Teams

Staffing

Well trained Peer Support Specialists can work in virtually any area of the mental health system. Some states require Peer Support Specialist Certification in order for the service to be Medicaid billable. Georgia Peer Support Specialist Project offers Certification Training to states, which was partially funded by SAMHSA. Typically, Certified Peer Support Specialists are required to minimally have a high school diploma or GED and a willingness to share their own recovery journey when helpful to others.

Peer Support Specialist may work part-time or full time and earn between \$10.00 and \$15.00 per hour.

Treatment Episode

Peer Support Specialists can serve consumers at any level of care and therefore PSS can be provided while the consumer is receiving services from the public system.

Intended Outcomes

- ✓ Decrease loneliness that leads to substance use, suicide, and crises;
- ✓ Increase readiness for change and engagement in treatment
- ✓ Increase community inclusion and participation

Other

- Quadrant Model: High Psychiatric/High Substance Use; High Psychiatric/Low Substance Use; and Low Psychiatric/Low Substance Use
- Any stage of change
- LOCUS: Levels 1-5

Additional evidence-based practices that can be blended with Peer Support Specialist Services include

- ✓ Family Psychoeducation
- ✓ Wellness Management and Recovery
- ✓ Assertive Community Treatment
- ✓ Integrated Dual Disorder Treatment
- ✓ Dialectical Behavior Therapy
- ✓ Virtually any practice that shares the foundational elements of Recovery Philosophy

Resources

Georgia Certified Peer Specialist Project March 2003 <http://www.gacps.org/Mission.html>

Psychosocial Clubhouse

Support or Service

Psychosocial Rehabilitation/Club House

Targeted Case Cohort

Adults with serious and persistent mental illness and co-occurring substance use disorders

Best Practice Classification

Promising Practice

Brief Description

The Clubhouse Model of Psychosocial Rehabilitation is a comprehensive and dynamic program of support and opportunities for people with severe and persistent mental illness. In contrast to traditional day treatment and other day program models, Clubhouse participants are called "members" (as opposed to "patients" or "clients") and restorative activities focus on their strengths and abilities, not their illness. The Clubhouse is unique in that it is not a clinical program, meaning there are no therapists or psychiatrists on staff. All clinical aspects of the program have been removed so as to focus on the strengths of the individual, rather than their illness. Additionally, all participation in a clubhouse is strictly on a voluntary basis.

The International Center for Clubhouse Development (ICCD) lays out four guaranteed Right of membership, which is at the core of the Clubhouse Model: 1) A right to a place to come; 2) A right to meaningful relationships; 3) A right to meaningful work; and 4) A right to a place to return.

The members and staff of a Clubhouse work side-by-side to manage all the operations of the Clubhouse, providing an opportunity for members to contribute in significant and meaningful ways; therefore, a Clubhouse is operated in a partnership model with members and staff working side-by-side as colleagues. Through this environment of support, acceptance, and commitment to the potential contribution and success of each individual, Clubhouses are places where people can belong as contributing adults, rather than passing their time as patients who need to be treated. The Clubhouse Model seeks to demonstrate that people with mental illness can successfully live productive lives and work in the community, regardless of the nature or severity of their mental illness. Currently, there are over 325 clubhouses in 28 countries around the world (ICCD, 2010).

- The PSR/Clubhouse models exhibit best practice by focusing on the principles of recovery.
- All members have equal access to the amenities, staff, and other resources regardless of diagnosis or level of pathology.
- Members establish their own schedules.
- Members share in the operation of the program.
- Staff and members work side by side.
- An ordered day is available and includes vocational, social and educational opportunities. Therapy or other treatment activities are provided after the ordered day.
- There are few staff, just enough to engage members and promote competence, independence and confidence and to point out vocational and social opportunities.
- The state of Iowa has 12 best practices related to PSR:
 - ✓ The member is involved and participates in all phases.
 - ✓ Services are individualized.
 - ✓ Services occur in natural settings.
 - ✓ Services are appropriate to need and risk factors.
 - ✓ Members receive the right intensity of service from appropriately trained staff.
 - ✓ Members participate in discharge planning.
 - ✓ Families and significant others are involved.
 - ✓ Services are integrated with treatment, crisis services, medication management and other supports.
 - ✓ Members evaluate the program for continuous improvement.
 - ✓ Members get involved in policy making.
 - ✓ Members receive a defined set of service activities.

The Iowa program also identifies four major areas of service:

- ✓ Readiness Development: orientation to recovery and planning
- ✓ Development to increase motivation and readiness
- ✓ Goal setting with informed choice
- ✓ Goals to address needed services - skill development
- ✓ Goal Keeping: practice and maintenance

Some other national programs utilize assign a single staff person assigned to provide one-on-one services to a single consumer (i.e. that same staff person may also be assigned to other cases but provides the services on a one-to-one per client basis. The service includes activities of daily living, interpersonal functioning, concentration-pace-persistence, adaptation to change and accommodation to social norms.

❖ **Clubhouse Units**

Clubhouses are divided into various work units designed to manage the everyday tasks associated with the operation of the clubhouse. Typical work units may include Clerical, Food Services, Facilities/Environmental, Reach Out (contacting and supporting members who have not attended the Clubhouse in a while), Membership, Education, Advocacy, Social Recreation, and Employment. The work of each unit is further divided into specific, manageable tasks. When a member joins the clubhouse, he or she selects a "home unit", according to his or her interests and abilities. The member can then sign up to perform the unit tasks, giving him or her an opportunity to work side-by-side with the clubhouse staff in a unique partnership and to contribute in meaningful ways to the overall operation of the clubhouse. All member contribution inside the clubhouse is done so on a voluntary basis; payment of a member to work in the clubhouse is considered unethical, regardless of work performed or hours put in.

❖ **Community Employment**

Clubhouses offer a tiered employment program designed to integrate interested members back into meaningful and gainful employment in the community. The first step of the program is Transitional Employment (TE), in which members can work in meaningful part-time jobs outside the clubhouse procured through partnerships with community entities and businesses. The member selected by the clubhouse community for these position(s) are trained by a clubhouse staff and/or member who are in charge of that particular placement. As an incentive to the employer, job attendance and performance are guaranteed, as a staff and/or member will support or even fill-in for the clubhouse member if he or she needs to be absent for any reason. Each member contribution at a Transitional Employment position is designed to be transitional and temporary, lasting for six to nine months, as these positions belong to the clubhouse, and are designed in such a way so that ideally all members will have an opportunity to work. Each member of a clubhouse who participates in a Transitional Employment position is guaranteed to earn minimum wage or above. Additionally, all clubhouse TE positions are entry level so that all members have the opportunity to work in all positions. The single most important factor in placing members in TE positions is the individual's desire to work.

The second step is supported employment, in which the clubhouse community helps an interested member obtain his or her own employment and serves as a resource and support for résumé makeup, interviewing skills, transportation, and employer liaisons.

The third step is independent employment, in which the member is meaningfully and gainfully employed without the intervention (but always with the support) of the clubhouse community.

❖ **Other Aspects of the Clubhouse Model**

In addition to in-house and community based work opportunities, clubhouses generally offer a wide array of other member services, including housing support and placement,

benefit advocacy, peer case management, financial planning, evening and weekend social programs, continuing education support, and regional and international conferences. As with all aspects of clubhouse operations, these services and programs are administered through the joint efforts of both clubhouse members and staff.

Staffing

Clubhouse programs serving 100 – 200 people daily, including holiday and weekend hours have highly variable costs depending on the number of professional staff. A Club House with a number of vocational units such as a restaurant unit, clerical unit, member services unit, may have increased costs for equipment and supplies. Club House units may also be funded to provide medication, therapies and case management (peer case management), and support clubhouse after hours. The total package for a comprehensive program for 200 members from among a general population of 200,000 lives and 20,000 Medicaid lives is approximately \$850,000. A significant portion of the funding can be from joint funding partnerships with vocational rehabilitation services for transitional employment and job readiness activity. The costs are highly variable depending upon the number of professional staff employed. The best programs have the fewest professional staff. These costs account for 6 professional staff, a supervisor, and vocational rehabilitation services.

Treatment Episode

Club House is designed to be time-unlimited. However, since Club Houses are publically funded (i.e. Medicaid), members are encouraged to volunteer over time, instead of continuing to be the recipient of Club House over a long period of time.

Intended Outcomes

- Decreased psychiatric hospitalization admissions and subsequent days of utilization
- Increased employment and retention
- Increased housing stability
- Increase social supports
- Decrease isolation

Other

- Quadrant Model: High Psychiatric/Low Substance Use or Low Psychiatric/Low Substance use
- Primarily for adults any Stage of Change.
- LOCUS: Levels 1-4

Additional evidence-based practices that can be blended with Club House include

- Wellness Recovery Action Planning (WRAP)

- Illness Management & Recovery

Resources

Recovery Supports Model of Practice

Support or Service

Recovery Supports Model- Providing an exit from Case Management

Targeted Case Cohort

Adults with Serious Mental Illness that are advanced in their recovery process.

Best Practice Classification

Compilation of evidence based practices

Brief Description

It was not that long ago when the word “Recovery” was absent from consumers, their families, and mental health professionals’ vernacular. Now, recovery is the expectation not the exception. People’s needs change as they grow. As a result, service models must change and grow too. The Recovery Supports Model is an example of how services and supports can focus on recovery and provide an exit from case management. An article by Lori Ashcraft and William A. Anthony in the Behavioral Healthcare May, 2009 edition entitled, “Providing an exit from case management: programs need to promote self-sufficiency (TOOLS FOR TRANSFORMATION)”, described how Alameda County in California developed new programs for people exiting case management, “Once a person is in case management there seems to be no planned way to exit. We think this is a carryover from the days before we knew about recovery. We didn’t expect people to recover, so we more or less planned on them being with us forever” (Ashcraft & Anthony, 2009).

The premise is, recovery focused supports are available when people need them and not, when they don’t need them. However, people will continue to transition to community resources that have benefited from specialty services and as a result have needs that can be met through private insurance and/or community resources. This model provides relief for case managers’ case loads. It is designed for people to “come” and “go” from recovery support services.

- ✓ Fluidity for consumers and is less expensive- people do not receive services they do not want or need. Only contact is when the person needs something and needs a quick response
- ✓ Available as an alternative to more traditional services
- ✓ Case Management and Clinical Assessments are available when there is a concern that a person’s needs have elevated or changed from what we have currently planned or understand

- ✓ Simple planning process through a one page plan where the person's needs is the focus of the plan
- ✓ All recovery support staff work as a team, there are no caseloads
- ✓ Scheduling of appointments is not the focus, people can drop in and receive individual and group recovery supports (e.g. WRAP, support & skills groups) from a Peer Support Specialist
- ✓ Psychiatrist is available on specific days of the week for those that need medication support
- ✓ WRAP Plans are encouraged for people who are ready to take responsibility for their recovery (Preparation, Action, and Maintenance Stages of Change)
- ✓ Group Therapy (in general, no individual therapy is available) for people that have more complex needs (based on the LOCUS)
- ✓ Practical/task oriented assistance- DHS paperwork, etc.
- ✓ Spend down paperwork assistance
- ✓ People that leave the Recovery Support can re-enter without going through an eligibility process
- ✓ Skill building/recovery management skills for both mental illness and substance use disorders (e.g., refusal skills, managing triggers and cravings, recognizing symptom onset, communication skills, etc.)
- ✓ Social Support- Encourage positive peer supports (e.g., self help groups)
- ✓ Cognitive Behavioral approaches- Assist consumers with transforming negative thoughts and behaviors into coping skills for both mental health and substance use disorders
- ✓ Quality Improvement focus is on ways to make the service responsive and more flexible as well as evaluate/remove administrative rules when necessary. This does not mean we remove the safety net of the Rights & Advocacy Protection System.

❖ **Admission Criteria**

People that can benefit most from the Recovery Support Program:

- ✓ People currently served by the mental health system that are advanced in their recovery and as a result have little dependency on the system (low need) but for many reasons (including lack of resources i.e. housing, meds, psychiatrist) remain in services; or
- ✓ People that have "graduated" that are seeking to re-enter.

Criteria:

- LOCUS Score of 10-16
- Through case consultation, determine if the identified consumers can be transitioned from the case management services to community/private resources; or transitioned to the Recovery Support Model;
- Consumers that have been stable in their recovery over the past one year as evidenced by:

- ✓ Consistent LOCUS scores
- ✓ No psychiatric acute care utilization (PHP, CRU, psychiatric inpatient); and
- ✓ No crisis interventions

Staffing

- Psychiatry
 - ✓ Psychiatric Evaluation 1 hour per 2 years
 - ✓ Medication Review 15 minute medication reviews per year
- Nursing
 - ✓ Nursing Assessment 1 hour per year
 - ✓ Health Services (e.g. blood pressure, body mass index, health education) 4 units per year
- Peer Support Specialist
 - ✓ Group Support (Wellness Recovery Action Planning) 12 groups per year; 1 hour duration;
 - ✓ Individual Support (e.g. employment assistance, housing assistance, etc.) 12 units per year
- Co-occurring Group Therapy- for those with higher need (LOCUS level 2)
 - ✓ 26 sessions per year

Treatment Episode

The average length of stay is 3-5 years.

Intended Outcomes

- Support and advance recovery
- Align services with needs
- Increase peer supports
- Focus on transition for people that can receive services in the community

Other

- Quadrant Model: Low Psychiatric/Low Substance Use
- Primarily for adults in the Action or Maintenance Stage of Change with a focus on:

- ✓ **Skill Building**- Teach illness management skills for both disorders (e.g., refusal skills, managing triggers and cravings, recognizing symptom onset, communication skills, etc.)
- ✓ **Social Support**- Encourage positive peer supports (e.g., self-help groups)
- ✓ **Cognitive Behavioral Interventions**- Assist consumers with transforming negative thoughts and behaviors into coping skills for both disorders.
- ✓ **Planning**- Develop a relapse-prevention plan; support consumers as they maintain lifestyle changes learned in active treatment
- ✓ **Recovery Lifestyle**- Help consumers set new goals for enhancing their quality of life
- ✓ **Social Support**- Reduce the frequency, intensity, and duration of relapses with positive peer relationships and supportive clinical relationships
- LOCUS: Level 1 and 2

Additional evidence-based practices that can be blended with Recovery Support Model include

- Supported Employment
- Cognitive Behavioral Therapy
- Illness Management & Recovery
- Wellness Recovery Action Planning

Resources

Supported Employment

Support or Service

Supported Employment

Targeted Case Cohort

Adults with serious and persistent mental illness and co-occurring substance use disorders and their supporters.

Best Practice Classification

Evidenced Based Practice

Brief Description

Supported Employment is an evidence based practice for adults with mental illnesses and co-occurring substance use disorders. The practice is delivered by Employment Specialists who are integrated with consumers' existing treatment teams. Supported Employment is based on:

- Work is an important part of the Recovery Process
- Focus on competitive employment paying at least minimum wage in the community
- Based on the person's preferences, abilities, and talents
- Research consistently shows that Supported Employment assists more consumers with getting and keeping their jobs than any other approach
- 70% of adults with severe mental illness want to work (SAMHSA, 2009c).

❖ Services Focused on Competitive Employment

Attainment and maintenance of competitive employment is the goal as opposed to sheltered work shop, enclaves, or other pre-employment services.

❖ Eligibility is Based on Consumer Choice

There is no exclusion criteria for those who want help finding work, which is often referred to as "Zero-Exclusion Criteria". Consumers are not excluded due to lack of work readiness, existence of a serious psychiatric diagnosis, history of hospitalizations, symptoms, or level of disability. Consumers that want competitive work in a job of their choice is the only eligibility criteria for the Supported Employment program.

❖ Rapid Job Search

Supported Employment programs utilize a rapid job search approach as opposed to pre-employment activities, prolonged employment assessment, skills training, job counseling, etc.

❖ **Integration of rehabilitation with mental health treatment**

The Supported Employment Specialists work in an integrated manner with the treatment team by attending treatment team meetings and regular communication with treatment team staff.

❖ **Attention to Consumer Preferences**

Employment search is based on consumer preferences and strengths instead of what may be the easiest jobs to develop.

❖ **Time-unlimited and Individualized Support**

Follow along supports continue indefinitely and not based upon artificial program deadlines.

❖ **Benefits Counseling**

Loosing of one's benefits (e.g. Medicaid, Supplemental Security Income) is the most common reason consumers are apprehensive about working. The Benefits Counseling component of Supported Employment provide individualized planning and guidance on an ongoing basis with each consumer to ensure well informed and optimal decisions regarding Social Security and health insurance.

Staffing

Employment Specialists are not frequently mental health professionals. Instead, they have experience in sales or business. Depending on the State's Medicaid Provider Manual, the Employment Specialist may be required to have a Bachelor Degree or in some states, a Peer Support Specialist with appropriate certification may meet the Medicaid qualifications. Supported Employment works best if the Employment Specialist is a member of the treatment team (e.g. ACT, Intensive Case Management, IDDT, etc.). The Employment Specialist's maximum case load size is 1:25 staff to consumer ratio.

Treatment Episode

Support Employment is time-unlimited but can be transitioned from the Employment Specialist to the on-going follow along provided by a Case Manager or Peer Support Specialist.

Intended Outcomes

Supported Employment Increases:

- ✓ Employment in competitive jobs
- ✓ Number of hours worked
- ✓ Amount of income earned in competitive jobs

Supported Employment Improves:

- ✓ Self esteem
- ✓ Improves self-management of mental
- ✓ Improves health symptoms
- ✓ Independent living
- ✓ Autonomy

Supported Employment Decreases:

- ✓ Unemployment
- ✓ Dependence upon public systems of care
- ✓ Symptoms of mental illness
- ✓ Hospitalizations
- ✓ Stigma in the community about mental illness (SAMHSA, 2009c).

Other

- Quadrant Model: High Psychiatric/Low Substance Use and Low Psychiatric/Low Substance Use
- Any stage of change
- LOCUS: Levels 1-5

Additional evidence-based practices that can be blended with SE include

- ✓ Family Psychoeducation
- ✓ Wellness Management and Recovery
- ✓ Assertive Community Treatment
- ✓ Integrated Dual Disorder Treatment
- ✓ Dialectical Behavior Therapy
- ✓ Virtually any practice that shares the foundational elements of Recovery Philosophy

Resources

Substance Abuse and Mental Health Services Administration. *Supported Employment: Building Your Program*. DHHS Pub. No. SMA-08-4364, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2009.

Targeted Case Management

Support or Service

Targeted Case Management (TCM)

Targeted Case Cohort

Adults with serious and persistent mental illness and co-occurring substance use disorders and their supporters.

Best Practice Classification

Not an Evidenced Based Practice

Brief Description

Targeted Case Management (TCM) is defined by the state of Iowa as case management services for anyone needing the following: medical, social, educational, housing, transportation, vocational, or other services for the benefit of an individual. In addition, if functional limitations impede the ability of an individual to obtain or access needed services, TCM can be beneficial.

❖ Assessment

TCM performs a comprehensive assessment and periodic reassessment to determine an individual's need for any medical, social, educational, housing, transportation, vocational or other services. The comprehensive assessment addresses the individual's areas of need, strengths, preferences, and risk factors, considering the individual's physical and social environment. A face-to-face reassessment must be conducted at a minimum annually and more frequently if changes occur in the individual's condition. The assessment and reassessment activities include the following:

- (1) Taking the individual's history, including current and past information and social history annually.
- (2) Identifying the needs of the individual.
- (3) Gathering information from other sources, such as family members, medical providers, social workers, legally authorized representatives, and others as necessary.

❖ Service Plan

A comprehensive service plan based on the comprehensive assessment, which includes crisis intervention plans based on the risk factors identified in the risk

assessment portion of the comprehensive assessment. TCM ensures the active participation of the individual and works with the individual or the individual's legally authorized representative and other sources to choose providers and develop the goals. This plan includes:

- (1) Specified goals and actions to address the medical, social, educational, housing, transportation, vocational or other services needed by the individual.
- (2) Identifies a course of action to respond to the individual's assessed needs, including identification of all providers, services to be provided, and time frames for services.
- (3) Include an individualized crisis intervention plan that identifies the supports available to the individual in an emergency. A crisis intervention plan identifies:
 1. Any health and safety issues applicable to the individual based on the risk factors identified in the individual's comprehensive assessment.
 2. An emergency backup support and crisis response system, including emergency backup staff designated by providers, to address problems or issues arising when support services are interrupted or delayed or the individual's needs change.
- (4) Includes a discharge plan.

❖ **Referral and Related Activities**

TCM help's individuals obtain needed services, such as scheduling appointments for the individual, and activities that help link the individual with medical, social, educational, housing, transportation, vocational or other service providers or programs that are capable of providing needed services to address identified needs and risk factors and to achieve goals specified in the service plan.

❖ **Monitor and Follow-up**

TCM performs activities and makes contacts that are necessary to ensure the health, safety, and welfare of the individual and to ensure that the service plan is effectively implemented and adequately addresses the needs of the individual. At a minimum, monitoring shall include assessing the individual, the places of service (including the individual's home when applicable), and all services. Monitoring may also include review of service provider documentation. Monitoring shall be conducted to determine whether:

- (1) Services are being furnished in accordance with the individual's service plan, including the amount of service provided and the individual's attendance and participation in the service.
 - (2) The individual has declined services in the service plan.
 - (3) Communication is occurring among all providers to ensure coordination of services.
 - (4) Services in the service plan are adequate, including the individual's progress toward achieving the goals and actions determined in the service plan.
 - (5) There are changes in the needs or status of the individual.
- Follow-up activities shall include making necessary adjustments in the service plan and service arrangements with providers.

❖ **Admission Criteria**

Typically individuals transitioning to living in the community are best suited for TCM. TCM statutes dictate eligibility criteria and length of services.

Staffing

Practitioner credentials are, at minimum, a bachelor degree.

Treatment Episode

TCM services vary depending on individual needs and ability to pay for services. TCM services are often most needed for individuals transitioning to living in the community. Services are provided for at least 60 days in these instances.

Intended Outcomes

- Increase access to services in a community setting.
- Improve ability of individual to participate fully in services.

Other

- Quadrant Model: High Psychiatric/Low Substance Use or High Psychiatric/High Substance use
- Primarily for adults in the Preparation, Action, and Maintenance Stage of Changes.
- LOCUS: Level 1, 2, 3, and 4

Additional evidence-based practices that can be blended with TCM

- Illness Self-Management & Recovery
- Family Psychoeducation
- Supported Employment
- Telemental Health
- Partial Hospitalization

Resources

Telemental Health

Support or Service

Telemental Health

Targeted Case Cohort

Adults with serious and persistent mental illness and co-occurring substance use disorders and their supporters.

Best Practice Classification

Best Practice

Brief Description

Telemental Health (TMH) is the practice of mental health specialties at a distance. TMH can include mental health assessment; treatment; education; monitoring and collaboration through the use of interactive videoconferencing. Patients have been able to utilize TMH in a variety of settings, including hospitals, clinics, schools, nursing facilities, prisons, and homes. The historical driving force for the development of this technology-based intervention was the issue of access to quality care, particularly in rural areas. Research has shown that in outpatient settings, patients can be reliably assessed, diagnosed, and treated with pharmacology and psychotherapy (American Telemedicine Association, 2009). Evidence has shown that patients adapt quickly to the technology and establish rapport at rates no different than those of face-to-face meetings (ATA, 2009). Patient education, as well as staff consultation or collaboration has been shown to be productive and successful (ATA, 2009).

❖ Technology

Videoconferencing is a communications tool that has made possible the recreation of clinical, consultative, and educational settings regardless of the geographic location of participants. A wide array of equipment and standards-based software is available that can greatly enhance the capabilities and usefulness of the videoconferencing system. TMH users where available, practical and affordable **should** be able to, when cost-effective:

- ✓ Display static pictures, diagrams, or objects.
- ✓ View and share a computer desktop or applications.
- ✓ Play videos or CDs so people at other locations can see and hear them.
- ✓ Record meetings when clinically appropriate and with patient permission.
- ✓ Share information on a common white board or via computer files.

Other desirable features of a videoconferencing system include:

- ✓ Ease of use with minimum operator training.
- ✓ Have remote camera control so that a clinician can pan, tilt, and zoom (PTZ) the camera on the patient end for close-ups.
- ✓ Easy-to-understand visual cues to give user feedback on features selected.
- ✓ On screen messages to notify the user of such conditions as loss of far end video, incomplete or dropped connections, mute/unmute etc.
- ✓ Option to view the picture sent as well as the picture received simultaneously (known as 'picture-in-picture' or PIP).
- ✓ Audio at 7 kHz full duplex with echo cancellation (capable of eliminating room return audio echo), with easy-to-use mute function and volume adjustment.
- ✓ Standard computer and peripheral ports for transmission of data.
- ✓ Ability to operate at a bandwidth of 384 Kbps or higher.
- ✓ Capacity for software upgrades as improvements become available.
- ✓ Currently, most videoconferencing takes place via digital telephone lines (ISDN) or over TCP/IP (utilizing a local area network (LAN), wide area network (WAN), or broadband Internet connection). Low bandwidth videophones are often found in home care programs, or in situations or areas where higher bandwidth connections are either unavailable or cost prohibitive.
- ✓ Satellite communications are increasingly being used in remote areas, whether for Internet connectivity, or direct satellite telephony.
- ✓ Conferencing can be established between just two locations (called point-to-point) or among a number of sites simultaneously (called multi-point).
- ✓ High-quality audio is essential to the success of TMH services, capturing the nuances of conversation that are often vital in making appropriate diagnoses.
- ✓ Microphone type and placement are extremely important, as are the acoustical properties of the room used. Most flat "conference-style" microphones are adequate to pick up sounds around a table or in a room, as long as the microphones are placed on a hard, flat surface at desk or table-top level. Many will also work well if placed on a flat wall at about head level for a seated person. If no flat surface is available, or if patients may be active or agitated, an omni-directional microphone can be hung from the center of the ceiling. "Quiet" rooms (those with carpeting, soft furniture, acoustical treatments, or other sound absorbing characteristics) allow for better intelligibility of transmitted speech.

❖ Transmission Speed & Bandwidth

Most TMH programs use systems that transmit data at a minimum of 384 Kbps. Transmission speed ***shall*** be the minimum necessary to allow the smooth and natural communication pace necessary for clinical encounters. Research into the quality of data transmission has shown that viewers perceive a marked difference in quality between 128 and 384 Kbps, but report less noticeable difference between 384 and 768 Kbps, although the proportionate cost increase is often much larger at the higher transmission speed. The use of lower bandwidths is necessary in some locations due to

lack of or expense of broadband access and the need to provide services to disparate and/or remote populations.

❖ **Standard Operating Procedures/Protocols**

- ✓ TMH organizations and providers ensure that appropriate staff is available to meet patient and provider needs before, during, and after TMH encounters of all types.
- ✓ Organizations and practitioners have agreements in place to assure licensing, credentialing, training, and authentication of patients and practitioners as appropriate and according to local, state, and national requirements.
- ✓ TMH organizations and practitioners are aware of the enhanced requirements for privacy and confidentiality that is afforded to patients receiving mental health care.
- ✓ TMH organizations and practitioners have billing and coding processes in place that share information across systems for the purposes of payment that do not risk exposure of mental health patients' personal health information.
- ✓ TMH organizations and practitioners determine processes for documentation, storage, and retrieval of TMH records. Specific descriptions in place address who can have access to the records.
- ✓ TMH organizations and practitioners shall have in place policies and procedures that address all aspects of administrative, clinical, and technical components regarding the provision of TMH and shall keep the policies and procedures updated on an annual basis or more often as needed.
- ✓ TMH organizations and practitioners have in place a systematic quality improvement and performance management process that complies with any organizational, regulatory, or accrediting, requirements for outcomes management.
- ✓ TMH organizations and practitioners comply with the specific consents to treat and for medication administration that apply to the area of mental health.
- ✓ Although no special consents are needed to use TMH to serve patients, additional layers of consent are required during the course of treatment of persons with mental health conditions.
- ✓ Procedures in place between organizations and TMH practitioners for the purposes of obtaining and sharing consents for mental health treatment and services.
- ✓ TMH professionals are aware of who has regulatory authority and any and all requirements (including those for liability insurance) that apply when practicing TMH in another jurisdiction (eg. Across state lines), with particular attention to the additional responsibility that might apply in mental health encounters.

❖ **Clinical Standards**

The TMH operation and its health professionals ensure that the standard of care delivered via TMH is equivalent to any other type of care that can be delivered to the patient/client, considering the specific context, location and timing, and relative

availability of in-person care._ Health professionals are responsible for maintaining professional discipline and clinical practice guidelines in the delivery of care in the TMH setting, recognizing that certain modifications may need to be made to accommodate specific circumstances._ Any modifications to specialty specific clinical practice standards for the TMH setting ensure that clinical requirements specific to the discipline are maintained._ Health professionals providing TMH services have the necessary education, training/orientation, and continuing education/professional development to insure they possess the necessary competencies for the provision of quality health services.

Staffing

TMH providers and staff include psychiatrists, nurse practitioners, physician assistants, social workers, psychologists, counselors, primary care providers and nurses.

Treatment Episode

Varies based on intervention or use of TMH.

Intended Outcomes

- Increased access to mental health services for rural and potentially isolated populations
- Increase the number of patients a particular clinician can serve
- Improve timeliness of services
- Decrease no-show rates

Research has demonstrated that TMH can be just as effective in a variety of settings and types of services as in-person services (ATA, 2009; Myers, Palmer, & Geyer, 2011). In addition, patients participating in TMH are more likely to keep appointments and follow treatment plans than patients involved in face-to-face care (Smith & Allison, 2001).

Other

- Quadrant Model: High Psychiatric/High Substance Use; High Psychiatric/Low Substance Use; Low Psychiatric/High Substance Use; and Low Psychiatric/Low Substance Use
- Any stage of change depending on intervention/use
- LOCUS: Level 1, 2, 3, 4, and 5

Additional evidence-based practices that can be blended with TMH include

- Inpatient
- Individual Dual Diagnosis Treatment
- Partial Hospitalization Programs

- Illness Self-Management & Recovery
- Family Psychoeducation

Resources

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